APPENDIX B–1

INSTRUCTIONS FOR QUARTERLY (ANNUAL) CLAIMS PROMPT PAYMENT REPORT

INSTRUCTIONS

Number of claims, for this report, means the actual number of requests for payment of benefits or requests for payment for services rendered within each of the five categories (physician, dental, other health care professional, hospital or other health care facilities). Multiple requests for the same service, within each of the five categories, should only be counted once. But any single request for payment, which involves multiple categories, should be counted in each category.

Amount of claims, for this report, means the actual amount requested for payment of benefits or the amount requested for payment for services rendered within each of the five categories (physician, dental, other health care professional, hospital or other health care facilities). Multiple requests for the same service, within each of the five categories, should only be counted once. But any single request for payment, which involves multiple categories, should be counted in each category.

The following refers to numbers of or amounts of claim as appropriate to the portion of the report being completed.

Column (1) PERIOD
List the calendar quarter and year. Include all prior quarters in the calendar year.

Column (2) TOTAL CLAIMS
Enter the total claims received in the quarter.

Column (3) DENIED INELIGIBLE
Enter claims that are denied because they are for an ineligible service or the health care service was not rendered by an eligible health care provider under the health benefits or dental plan. Reductions for deductibles, coinsurance, or limits, or similar features, are not considered denials of either the claim or the claimed amount.

Column (4) DENIED DOCUMENT
Enter claims that are rejected at their initial submission because of a lack of substantiating documentation.

Column (5) DENIED CODING/ENROLLMENT
Enter claims that are rejected at their initial submission because of incorrect coding or incorrect enrollment information.

Column (6) DENIED FOR AMOUNT
Enter claims that are rejected at their initial submission because of the amount claimed.

Column (7) TIME LIMIT SPECIAL
Enter claims that are not paid in accordance with the time limit established by law because you deem the claim to require special treatment that prevents timely payments from being made.

Column (8) TIME LIMIT OTHER
Enter claims that are not paid in accordance with the time limits established by law even though the claims meet the criteria established by law.

Column (9) DENIED REFERRED FRAUD
Enter claims that are denied or referred to your fraud investigation unit, if applicable, or to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L. 1998, c.21 (C.17:33A-16) because you have reason to believe that the claim has been submitted fraudulently.

Column (10) INTEREST PAID
Enter claims upon which the 10 percent interest penalty established by law has been paid.

Column (11) INTEREST AMOUNT PAID
Enter the aggregate amount of interest paid in the quarter on the claims included in Column (10).

Column (12) TOTAL COLUMNS (3) TO (10)
Add the results entered in Columns 3 through and including Column 10.

Column (13) TOTAL PAID
Enter the total claims paid in the quarter including claims which may have been received in prior quarters and are now being paid.

SUBCHAPTER 2. HEALTH WELLNESS PROMOTION PLANS

11:22–2.1 Scope

This subchapter applies to health benefits plans that are delivered, issued, executed or renewed in this State on or after (the effective date of this subchapter).

11:22–2.2 Definitions

The following words and terms, when used in this subchapter, shall have the meanings as set forth below, unless the context clearly indicates otherwise:

"Act" means the Health Wellness Promotion Act, P.L. 1993, c.327, as amended by P.L. 1999, c.339.